Testimony of Professor Gerald Friedman to the Rhode Island House and Senate Committees - in support of *H5628/S0233* and *H5019/S230* March 4, 2021.

My name is Gerald Friedman. I am a professor of economics at the University of Massachusetts at Amherst. I have lived in New England since August 1978, when I moved to Cambridge to attend Harvard, where I was awarded a Ph.D. in economics in 1986. Since 1984, I have taught at the University at Massachusetts at Amherst where I have specialized in labor economics, public policy, and economic history. I have served as Department Chair, Undergraduate Program Director in Economics, Chair of the Personnel Committee in the College of Social and Behavioral Sciences, and other positions.

I have been involved in the debate over health care financing since the 1970s when I went to Washington to support Senator Ted Kennedy's proposed national Medicare-for-all system. Since then, every Democratic presidential nominee and president has proposed reforming our health care system to address the toxic combination of rising costs and declining coverage. Yet, the situation has only become worse: we now spend 18% of our gross domestic product on health care, and rising health care costs have swallowed up much of the increase in wages over the past decades as well as a disproportionate share of state and local spending (see Figure 1). Throughout the country, we are reducing spending on all forms of consumption as well as vital investments in our children's education and in infrastructure to feed the rising cost of health care.

Worse, we are not getting our money's worth for our spending because health care spending is much less efficient in the United States than elsewhere. Compared with the average for other affluent countries, we spend over twice as much but have a life expectancy 2.5 years less. If we are only going to settle for the life expectancy of people in Chile, then why are we spending over $7,000 more per person (see Figure 2)?

This is a national problem and I do not envy your position because state and local officials have to deal with the cost of our failure to enact a sensible national health care program. Indeed, Rhode Island has done well in providing greater access to health care, although less well in controlling costs so that there is a continuing squeeze on the budgets of families, businesses, and governments.

The problem of health care costs

Of course, we will control health care spending and we will do it in one of two ways: either we will control administrative bloat, monopoly pricing and excessive profits, or we will reduce access to health care services. So far, as a nation, we have been doing the latter, reducing access to services with higher copayments and deductibles to the point where Americans are less likely to see a physician than residents of other affluent countries and thousands die for lack of care. This is clearly wrong. While these policies discourage people from using health care and will make us less healthy, they do not address the source of America's out-of-control health care spending. International studies make it clear that our health care spending is not high because we use too many services; instead, our spending is out

of line with other advanced economies because our health care *prices* are so high.[1] In 2007, the McKinsey Global Institute found, for example, that drug prices in the United States were 60% higher than elsewhere and that we spend about $30 billion more on medical devices because of inflated prices - over 25% higher than the world average.[2] Even President Trump's Council of Economic Advisers acknowledges that drug prices are much higher in the United States than in Europe, with a markup of 80% in the United States instead of 20% in Europe.[3] The Massachusetts Attorney General's office has found enormous variation in hospital prices for the same procedures reflecting the bargaining power of privileged hospitals.[4] Other business-oriented researchers have similarly found that inflated prices and monopoly power, *not* utilization, account for high and rising health care costs in the United States.[5]

High and rising prices for health care in the United States are due to our reliance on a for-profit financing system that necessarily generates waste and cannot control monopolistic practices. I do not mean to name-drop, but of course, I will. My graduate-school professor, then Harvard Professor and Nobel-laureate Kenneth Arrow, showed 50 years ago that health care is not a commodity like shoes; because

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[1] Irene Papanicolas, Liana R. Woskie, and Ashish K. Jha, "Health Care Spending in the United States and Other High-Income Countries," *JAMA* 319, no. 10 (March 13, 2018): 1024–39, https://doi.org/10.1001/jama.2018.1150; Gerard F. Anderson et al., "It's The Prices, Stupid: Why The United States Is So Different From Other Countries," *Health Affairs* 22, no. 3 (May 1, 2003): 89–105, https://doi.org/10.1377/hlthaff.22.3.89.

[2] McKinsey Global Institute, "Accounting for the Cost of Health Care in the United States," January 2007, http://www.mckinsey.com/mgi/rp/healthcare/accounting_cost_healthcare.asp; Diana Farrell et al., "Accounting for the Cost of US Health Care: A New Look at Why Americans Spend More" (McKinsey Global Institute, December 2008); Commonwealth Fund, "A High Performance Health System for the United States," November 15, 2007, http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Nov/A-High-Performance-Health-System-for-the-United-States--An-Ambitious-Agenda-for-the-Next-President.aspx.

[3] Of course, their concern is that European prices are too low rather than US prices being too high! See Council of Economic Advisers, "Reforming Biopharmaceutical Pricing at Home and Abroad" (Washington, D. C.: White House, February 2018), https://www.whitehouse.gov/wp-content/uploads/2017/11/CEA-Rx-White-Paper-Final2.pdf.

[4] Office of Massachusetts Attorney General Martha Coakley, "Investigation of Health Care Cost Trends and Cost Drivers," January 29, 2010, http://www.mass.gov/Cago/docs/healthcare/Investigation_HCCT&CD.pdf; Zack Cooper et al., "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*" (Health Care Pricing Project, December 2015), http://www.healthcarepricingproject.org/sites/default/files/pricing_variation_manuscript_0.pdf; Reed Abelson, "Merged Hospitals Gain Both Power and Critics," *The New York Times*, September 26, 2002, sec. Business, http://www.nytimes.com/2002/09/26/business/merged-hospitals-gain-both-power-and-critics.html.

[5] Robert Kelly, "Where Can $700 Billion in Waste Be Cut Annually from the U.S. Health Care System?" (Healthcare Analytics, Thomson Reuters, October 2009), https://healthleadersmedia.com/content/241965.pdf; "Bloomberg Best (and Worst). Most Efficient Health Care: Countries," n.d., http://www.bloomberg.com/visual-data/best-and-worst/most-efficient-health-care-countries; Institute of Medicine (US) Roundtable on Evidence-Based Medicine et al., "Prices That Are Too High," Text, 2010, http://www.ncbi.nlm.nih.gov/books/NBK53933/; Steven Brill, *America's Bitter Pill: Money, Politics, Back-Room Deals, and the Fight to Fix Our Broken Healthcare System* (New York: Random House, 2015); "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America - Institute of Medicine," accessed May 10, 2013, http://www.iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx; Donald Berwick and Andrew Hackbarth, "Eliminating Waste in US Health Care," *JAMA: The Journal of the American Medical Association* 307, no. 14 (2012): 1513–16; CAP Health Policy Team, "Medicare Extra for All," *Center for American Progress* (blog), accessed February 25, 2018, https://www.americanprogress.org/issues/healthcare/reports/2018/02/22/447095/medicare-extra-for-all/.

of risk and uncertainty, we cannot expect health insurance markets to function like those of other commodities.[6] Insurance companies do not profit by selling more; instead, they profit by screening their customers so that they sell less insurance to people who will need it.[7] In his coffee business, for example, my father tried to provide quality coffee at a reasonable price because his profits grew when he sold more coffee to more people. Health insurance companies increase profits by *reducing* sales, by identifying those likely to be sick and *denying* them coverage. Almost 70% of what insurers call their medical "losses," payments made to providers, go for as few as 10% of people covered.[8] This creates a powerful incentive for insurers to identify those people and get them to drop their coverage or change insurers. If you can do this, if you can "cherry pick" healthy people and "lemon drop" those who will become sick, you can dramatically lower your "losses" (what we call insurance benefits) and increase profits. Expensive practices, like clinical review and requirements for prior authorization, practices that demean the sick and needy while wasting valuable provider time and insurance resources, are not accidents or mistakes but are practices designed to lower insurance company costs by driving away those who may need insurance the most.

Waste, therefore, is not an accident but is intrinsic to our for-profit health care system and our system of private health insurance. Even without any ill will or malice, insurers business model depends on driving out the needy with bureaucratic systems that drive up costs even while increasing profits. A recent analysis from Stanford Business School characterized this as administrative "sludge" that costs businesses money, wastes workers' time, and undermines their morale.[9] This waste, this sludge that is destroying our economy, is inherent to our system of private, for-profit health insurance. Companies that fail to screen their enrollees risk plunging into an "insurance death spiral" where a less-healthy population leads to rising costs and higher premiums that discourage the healthy from buying coverage making the population enrolled less healthy, raising costs further and requiring higher premiums. Similarly, investors will quickly replace any drug company executives or hospital administrators who fail to focus on branding and the search for monopoly profits because their business is not to provide health care but to create profits.

Waste is only part of the problem with private health insurance. The rest is the overcharging coming from inflated prices, especially those charged by elite, so-called "must have" hospitals and prescription

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[6] Kenneth Arrow, "Uncertainty and the Welfare Economics of Medical Care," *American Economic Review* 53, no. 5 (December 1963): 142–49.

[7] The Affordable Care Act includes restrictions on screening practices by requiring insurers to sell policies without regard for pre-existing conditions and forbidding rescissions, or the cancellation of policies because of illness. While welcome, these restrictions cannot prevent more subtle exclusionary policies such as targeted marketing and the use of bureaucratic barriers to access.

[8] This is from an analysis of the individual data in the Medical Expenditure Panel Survey, or the MEPS, household component at https://www.meps.ahrq.gov/mepsweb/survey_comp/household.jsp

[9] Jeffrey Pfeffer, "Magnitude and Effects of 'Sludge' in Benefits Administration: How Health Insurance Hassles Burden Workers and Cost Employers," Stanford Graduate School of Business, accessed February 27, 2021, https://www.gsb.stanford.edu/faculty-research/publications/magnitude-effects-sludge-benefits-administration-how-health-insurance.

drugs and medical devices. The unfettered exercise of monopoly power has raised prices for Americans using health care. Public attention has been focused on pharmaceutical and drug prices.[10] The attention paid pharmaceutical prices should not distract from other areas of monopoly pricing. A decade ago, the Massachusetts Attorney General warned that elite hospitals were charging prices 4 to 5 times as high as other providers for the same service.[11] Similar findings where the consolidation of hospital networks and physician practices have pushed up hospital prices and inflated managerial salaries. The median charge for inpatient procedures in California districts with market consolidation is nearly double that in districts with less market concentration.[12]

Individual health insurers lack the market clout to resist the demands of networks and elite hospitals. They acknowledged this during the debate over the Affordable Care Act when insurance industry lobbyists -- notably Karen Ignagni of America's Health Insurance Plans (AHIP) -- supported Obama Administration initiatives in alliance with Administration economists who sought to strengthen insurance companies against hospitals and drug companies.[13] These efforts largely failed, and most insurers do little to resist the demands of monopoly providers who will, in some cases, charge four or more times the charge in other hospitals for the same services.[14]

Only one insurer currently has market power to balance that of elite hospitals with control over provider networks: Medicare. Using its market power, Medicare has been able to restrain hospital price

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[10] Amazingly, their recommendation is to raise prices elsewhere; Council of Economic Advisers, "Reforming Biopharmaceutical Pricing at Home and Abroad."

[11] Office of Massachusetts Attorney General Martha Coakley, "Investigation of Health Care Cost Trends and Cost Drivers"; Martha Coakley, "Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 118G, § 6½(b) Report, 2011" (Boston, Mass.: Attorney General of Massachusetts, 2011), http://www.mass.gov/ago/docs/healthcare/2011-hcctd.pdf.

[12] Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, "Consolidation in California's Health Care Market 2010-2016: Impact on Prices and ACA Premiums" (Berkeley, Calif.: School of Public Health, University of California, Berkeley, March 26, 2018), http://petris.org/wp-content/uploads/2018/03/CA-Consolidation-Full-Report_03.26.18.pdf; Also see Ge Bai and Gerard F. Anderson, "Extreme Markup: The Fifty US Hospitals With The Highest Charge-To-Cost Ratios," *Health Affairs* 34, no. 6 (June 1, 2015): 922–28, https://doi.org/10.1377/hlthaff.2014.1414; Reed Abelson, "Hospital Prices," *The New York Times*, May 9, 2019, sec. Health, https://www.nytimes.com/interactive/2019/admin/100000006498140.embedded.html?; Barry Meier, Julie Creswell, and Jo Craven McGinty, "Hospital Billing Varies Wildly, U.S. Data Shows," *The New York Times*, May 8, 2013, http://www.nytimes.com/2013/05/08/business/hospital-billing-varies-wildly-us-data-shows.html; Eric Lopez, Gretchen Jacobson, and Larry Levitt, "How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature," *The Henry J. Kaiser Family Foundation* (blog), April 15, 2020, https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/; American Hospital Association, "Underpayment by Medicare and Medicaid Fact Sheet," December 2017, https://www.aha.org/system/files/2018-01/medicaremedicaidunderpmt%202017.pdf.

[13] Bob Herman, "Seismic Changes in the Health Insurance Industry Bring Opportunities and Friction," accessed September 10, 2017, http://www.modernhealthcare.com/article/20160130/MAGAZINE/301309964; Paul Starr, *Remedy and Reaction, the Peculiar American Struggle over Health Care Reform* (New Haven: Yale University Press, 2011), http://site.ebrary.com/lib/amherst/Doc?id=10506565; Brill, *America's Bitter Pill*.

[14] Meier, Creswell, and McGinty, "Hospital Billing Varies Wildly, U.S. Data Shows"; Office of Massachusetts Attorney General Martha Coakley, "Investigation of Health Care Cost Trends and Cost Drivers."

increases, and the smaller increases in physician prices, holding down the rate of inflation in healthcare. This has created a growing gap between the high prices charged private health insurers and the price hospitals charge Medicare although there is some evidence that Medicare rates may be as much as 9% below the actual cost (including both variable and average fixed costs) of providing hospital services.[15]

Lowering hospital prices to Medicare rates with an increase in these rates of 10% would save nearly $2 billion in Rhode Island in 2021. That is nearly $1,800 per person. Where else can you save your constituents that much money?

Economic waste is, of course, only part of the problem. You have done well in Rhode Island in extending care but even here, in one of the country's best health-care systems, over 4% of the population is without health insurance, and many more have policies with such high cost sharing that they cannot afford to see a doctor except in the direst circumstances.[16] It has been estimated that in normal times lack of health insurance accounts for 68,000 excess deaths in the United States. And these are not normal times. Since the onset of the Covid-19 pandemic, those without health insurance have delayed seeking care, by about 4 days more after the onset of symptoms, so that they have spread disease among more people and, when they have sought care, they have been sicker and more likely to need hospitalization. Overall, lack of health insurance can account for an additional 100,000 deaths from Covid, half the gap between Covid mortality in the US compared with other countries.

Single payer is the solution to rising costs

Our health care cost crisis is driven by administrative waste due to the insurance industry and to monopolistic pricing. The Affordable Care Act limits administrative costs and profits to only 15% of the standard group insurance plan, a rate that is nearly ten times the administrative rate of Medicare, with nearly $200 billion dollars of extra costs. The fastest increases in cost in the American health care system over the last decades have been in drug prices, hospital prices, and administrative activities.[17]

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[15] Lopez, Jacobson, and Levitt, "How Much More Than Medicare Do Private Insurers Pay?"; Robert A. Berenson, "Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets The Final Report of the Academy's Panel on Pricing Power in Health Care Markets" (National Academy of Social Insurance, April 2015); Christopher F. Koller and Dhruv Khullar, "The Commercial Differential for Hospital Prices: Responses From States and Employers," *JAMA* 322, no. 8 (August 27, 2019): 723–24, https://doi.org/10.1001/jama.2019.9275.

[16] Amitabh Chandra, Evan Flack, and Ziad Obermeyer, "The Health Costs of Cost-Sharing," n.d., 56; Zarek C. Brot-Goldberg et al., "What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics," Working Paper (National Bureau of Economic Research, October 2015), http://www.nber.org/papers/w21632.

[17] William H. Shrank, Teresa L. Rogstad, and Natasha Parekh, "Waste in the US Health Care System: Estimated Costs and Potential for Savings," *JAMA*, October 7, 2019, https://doi.org/10.1001/jama.2019.13978; Commonwealth Fund, "A High Performance Health System for the United States"; Woolhandler S Himmelstein DU, "Cost Control in a Parallel Universe: Medicare Spending in the United States and Canada," *Archives of Internal Medicine*, October 29, 2012, 1–2, https://doi.org/10.1001/2013.jamainternmed.272; Gerald Friedman, "Universal Health Care: Can We Afford Anything Less?," *Dollars and Sense*, June 29, 2011, http://dollarsandsense.org/archives/2011/0711friedman.html; Steffie Woolhandler and David Himmelstein, "Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower

Administrative costs have risen in the United States at a rate of over 11% a year since 1971, rising from a bit over 1% of GDP to over 5% now. Compared with Canada's single payer system, administrative cost increases account for over two-thirds of the excess increase in our health care costs. Perhaps most revealing, there is no difference between the cost increases in Canada's Medicare single-payer system and our Medicare single-payer-system for the elderly; had all of the US health care system behaved like our Medicare system, we would be spending a third less than we spend now, about what Canada spends per person to gain longer life expectancy than we have in the United States.

Rising administrative costs are the price we pay for a broken system of private health insurance, a system designed to increase industry profits even while denying adequate health care to growing numbers of our citizens. Ask yourself and your constituents, what do we get in exchange for handing billions of dollars over to the insurance industry and to monopolistic drug companies and others? Fortunately, there is an alternative to this bloated and inefficient system. A single-payer health insurance system could dramatically lower costs by eliminating much of the administrative burden both within health insurance companies and within provider offices' billing and insurance operations. Combined with savings to be realized by reducing administrative costs in the operation of health insurers and in providers' offices and by reducing market power in areas like prescription drugs, even after expanding coverage to all residents, Rhode Island would save nearly $3 billion this year with a single payer system (see Table 1 and Figure 3), $3,000 per person while *improving* healthcare and saving lives. If we can lower health care spending by nearly 20% while *improving* access for all residents of the State, what are we waiting for?

Paying for Single Payer in Rhode Island

A single-payer system would benefit all with the greatest benefits for the poor. We could finance a universal insurance system in Rhode Island covering everyone without copayments or deductibles in a variety of ways while leaving more money for most Rhode Islanders. One such funding plans is suggested in Table 1 which gives estimates of moneys collected from a 10 percent payroll tax combined with a 10 percent tax on capital gains, interest, profits, and rents.[18] This would replace insurance premiums and most out-of-pocket spending so that over 80% of residents would save money. And it would give the state the tools to control future health care costs.

Businesses would also benefit because a payroll tax of 10 percent would lower payroll costs by over 3 percent compared to what businesses now pay for health insurance. When added to significant administrative savings within companies, single-payer would dramatically enhance the competitiveness of Rhode Island companies. A conservative estimate would be that by lowering the cost of business

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Costs," *Annals of Internal Medicine*, February 21, 2017, http://annals.org/aim/article/2605414/single-payer-reform-only-way-fulfill-president-s-pledge-more; Gene Emery, "Cancer Drug Prices Rising Far Faster than Inflation," *Reuters*, October 18, 2017, https://www.reuters.com/article/us-health-cancer-drug-prices/cancer-drug-prices-rising-far-faster-than-inflation-idUSKBN1CN285.

[18] After establishing a working reserve, surplus revenues would be returned to the public through a premium holiday at the end of the year.

these savings would lead to an expansion in sales and production that would increase employment in the state by nearly 3%, or over 14,000 additional jobs. Do we want these jobs, or would we rather Massachusetts or New York get them by reforming their health care systems first. What are we waiting for?

Because health insurance is an especially large share of local government expenditures, the state's cities and towns would be among the biggest winners from adopting a single payer health program. Local governments will be spending over 20% of payroll on health insurance; a single-payer system would bring these costs down to 10% of payroll. Do you have another way to provide this much help for your districts' localities. To repeat myself: what are we waiting for?

Single payer would also resolve one of the most vital issues facing Rhode Island today: the cost of unfunded retiree health benefits for teachers and other state employees. These are contractual benefits promised employees in exchange for their receiving lower wages during the course of their employment.[19] Now, Rhode Island's tax payers face a bill of as much as $10 billion for these benefits.[20] We could complain that these benefits should have been funded at the time that the commitments were made; or we could complain about healthcare inflation that has driven up the cost of these commitments. But they are legal obligations of the state and localities, obligations that will disappear under single payer because the state's retirees will receive better access at lower cost mixed into the general cost of healthcare. How would you feel about never again having to think about OPEB?

Again, to repeat myself: what are we waiting for?

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[19] Andrew Biggs and Jason Richwine, "Overpaid or Underpaid? A State-by-State Ranking of Public-Employee Compensation," Working Paper, AEI Economic Policy (Washington, D. C.: American Enterprise Institute, April 24, 2014), https://www.aei.org/wp-content/uploads/2014/04/-biggs-overpaid-or-underpaid-a-statebystate-ranking-of-public-employee-compensation_112536583046.pdf; Jeffrey Keefe, "Public-Sector Workers Are Paid Less than Their Private-Sector Counterparts—and the Penalty Is Larger in Right-to-Work States," *Economic Policy Institute* (blog), accessed June 5, 2020, https://www.epi.org/publication/public-sector-workers-are-paid-less-than-their-private-sector-counterparts-and-its-much-worse-in-right-to-work-states/; Austin Frakt, "Would Your Wages Rise Under 'Medicare for All'?," *The New York Times*, February 3, 2020, sec. The Upshot, https://www.nytimes.com/2020/02/03/upshot/wages-medicare-for-all.html.

[20] Rhode Island Public Expenditure Council, "Analysis of Rhode Island's Debt Including Pension and OPEB Obligations – Rhode Island Public Expenditure Council," accessed March 3, 2021, https://ripec.org/analysis-of-rhode-islands-debt-including-pension-and-opeb-obligations-2/.

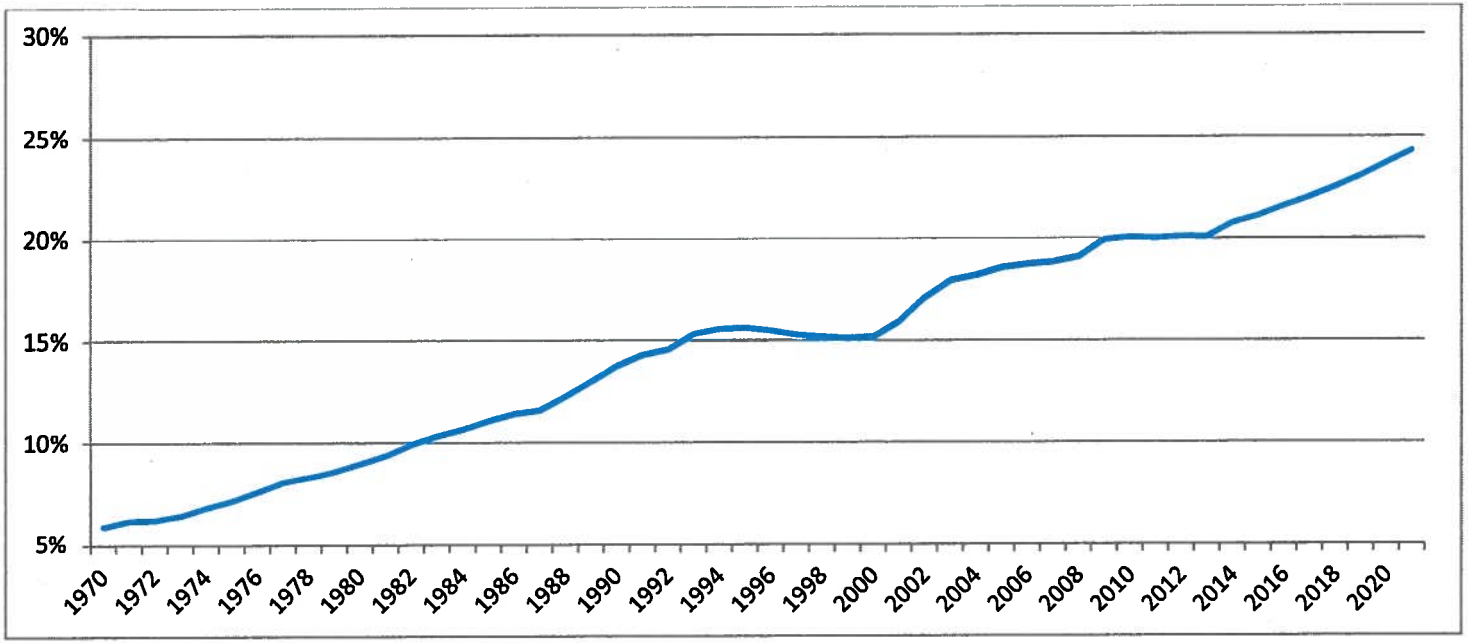

Figure 1. Per-Capita Health Care Spending to Average Wage, United States since 1970.

Note: This figure shows the ratio of per capita health care spending to the average wage reported to the Social Security Administration.

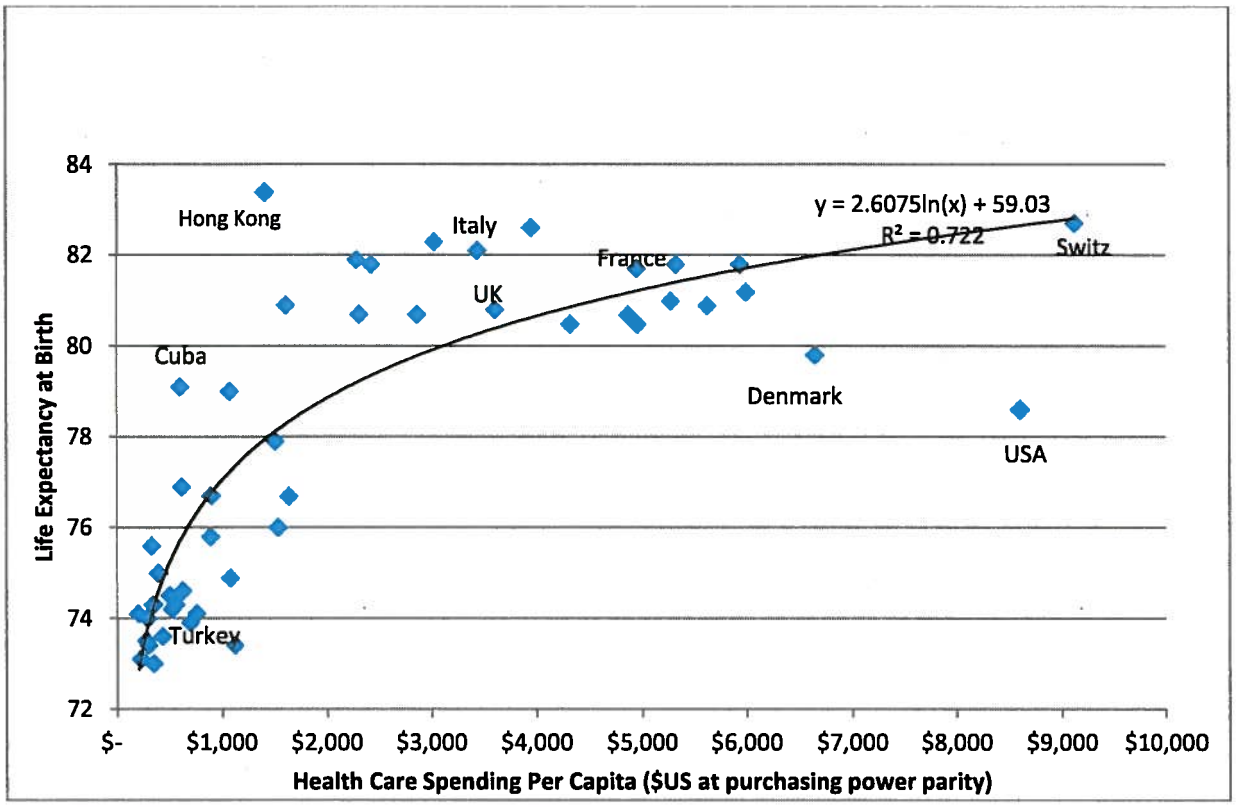

Figure 2. Life Expectancy and per-capita Health Care Spending, National Averages.

Note: This figure compares average life expectancy at birth to per capita health care spending around 2010. The regression line gives the average life expectancy value for each level of spending. Note that the United States is significantly below the line, indicating that we have a life expectancy over two years less than would be expected given our level of spending.

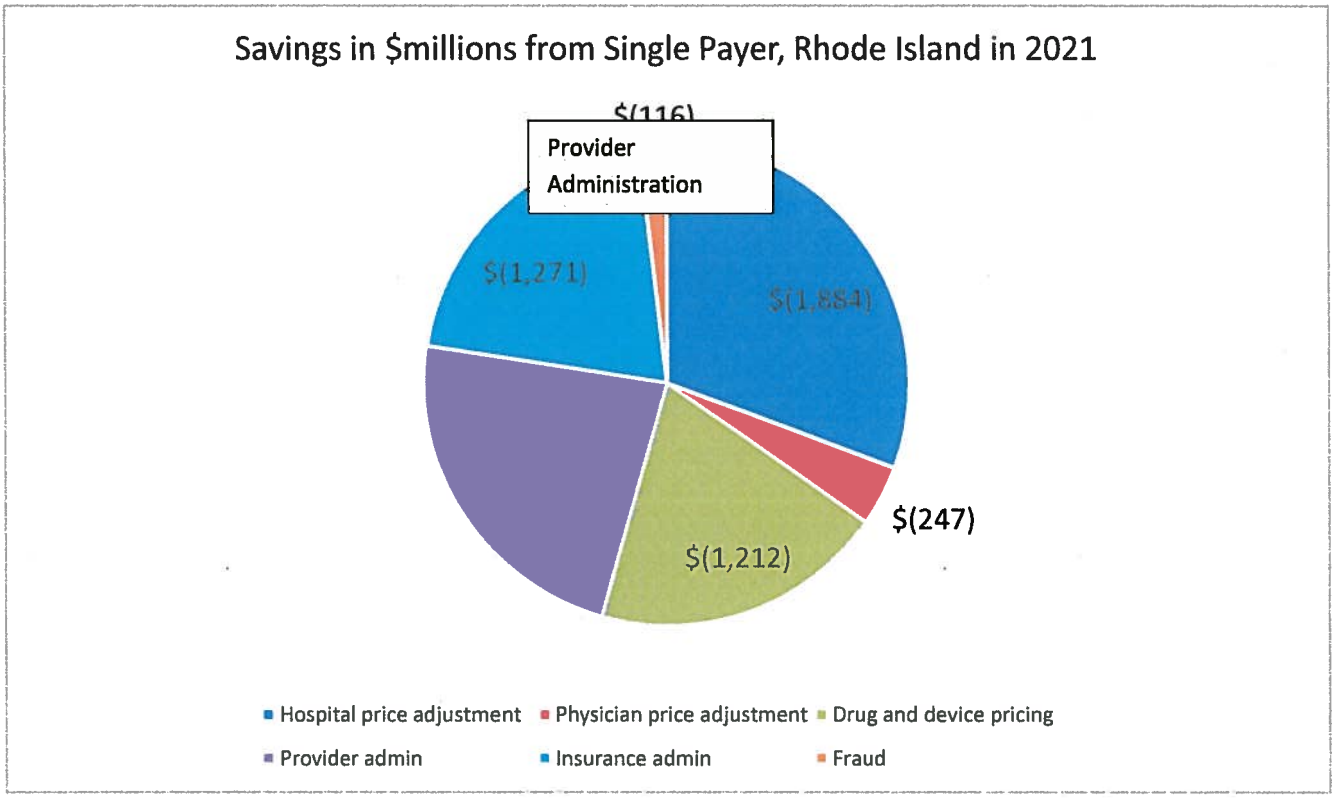

Figure 3. Savings in $millions from Single Payer, Rhode Island 2021.

Note: This figure represents anticipated savings from a single payer system in Rhode Island in 2021.

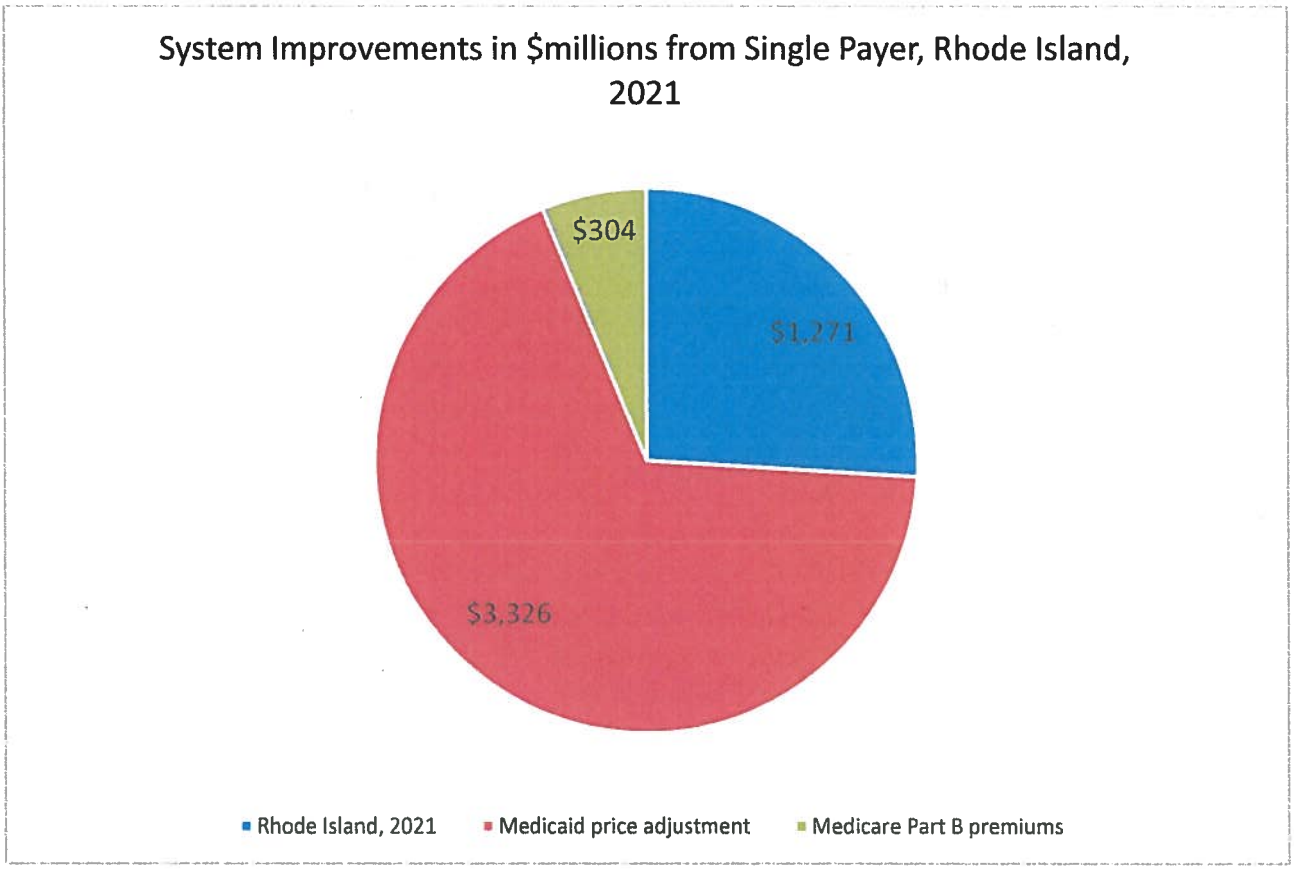

Figure 4. System Improvements in $millions from Single Payer, Rhode Island, 2021

Table 1. Funding single payer, Rhode Island, 2021

Spending with universal coverage, existing system		
Personal health care, current utilization	$	11,717
Improved access	$	1,271
Total personal healthcare	$	12,988
Insurance admin	$	1,500
Total, existing system with full access	$	14,488
Savings from existing system, with universal coverage		
Hospital price adjustment	$	(1,884)
Physician price adjustment	$	(247)
Drug and device pricing	$	(1,212)
Provider admin	$	(1,414)
Medicaid price adjustment	$	3,326
Insurance admin	$	(1,271)
Fraud	$	(116)
Total savings	$	(2,818)
Funding of Rhode Island universal program		
Net spending, 2021, M4All	$	11,670
Including Medicare Part B	$	11,974
Existing revenue	$	8,912
Needed revenue	$	3,062
10% payroll	$	2,939
10% unearned income	$	832
Revenue	$	3,770
Surplus (or deficit)	$	708

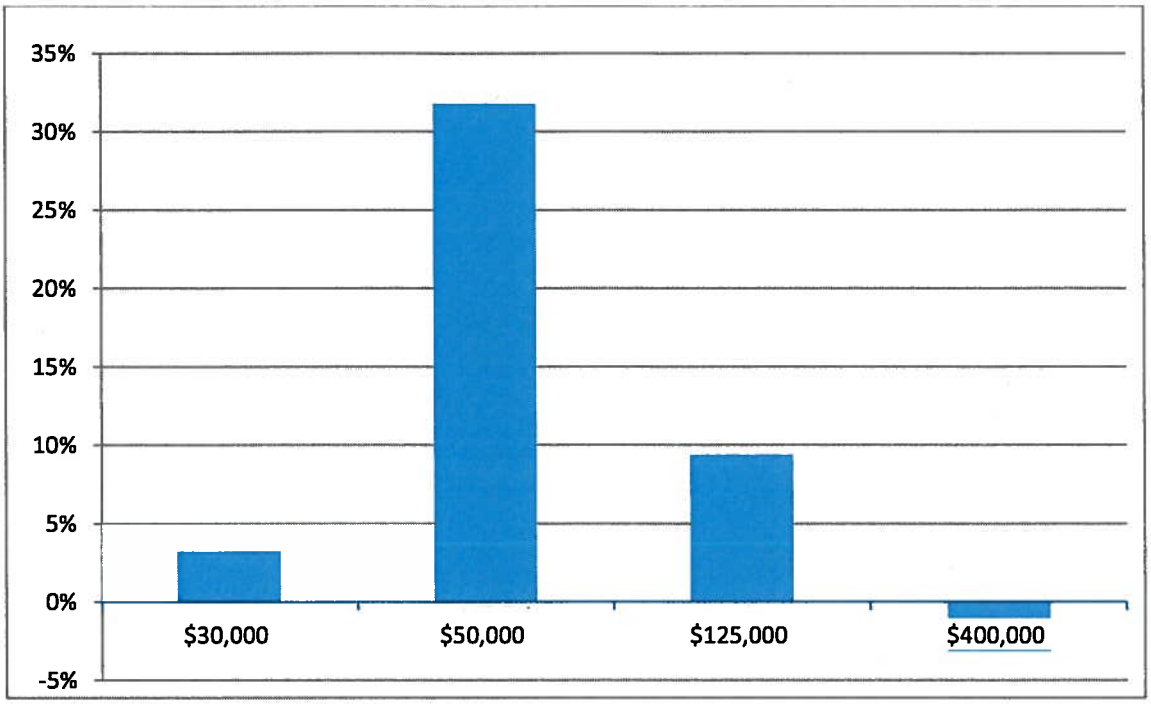

Figure 5. Effect of single-payer financed with 10% payroll tax and 10% tax on rents, dividends, profits, capital gains. Effect on income by income level.

Note: This shows the percentage change in income after taxes and health care expenses of a single-payer program in Rhode Island that replaced all health expenditures except 20% of out-of-pocket costs with a state program funded with a 10% payroll tax and a 10% tax on income from dividends, interest, profits, and rents.

References

Abelson, Reed. "Hospital Prices." *The New York Times*, May 9, 2019, sec. Health. https://www.nytimes.com/interactive/2019/admin/100000006498140.embedded.html?

———. "Merged Hospitals Gain Both Power and Critics." *The New York Times*, September 26, 2002, sec. Business. http://www.nytimes.com/2002/09/26/business/merged-hospitals-gain-both-power-and-critics.html.

American Hospital Association. "Underpayment by Medicare and Medicaid Fact Sheet," December 2017. https://www.aha.org/system/files/2018-01/medicaremedicaidunderpmt%202017.pdf.

Anderson, Gerard F., Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan. "It's The Prices, Stupid: Why The United States Is So Different From Other Countries." *Health Affairs* 22, no. 3 (May 1, 2003): 89–105. https://doi.org/10.1377/hlthaff.22.3.89.

Arrow, Kenneth. "Uncertainty and the Welfare Economics of Medical Care." *American Economic Review* 53, no. 5 (December 1963): 142–49.

Bai, Ge, and Gerard F. Anderson. "Extreme Markup: The Fifty US Hospitals With The Highest Charge-To-Cost Ratios." *Health Affairs* 34, no. 6 (June 1, 2015): 922–28. https://doi.org/10.1377/hlthaff.2014.1414.

Berenson, Robert A. "Addressing Pricing Power in Health Care Markets: Principles and Policy Options to Strengthen and Shape Markets The Final Report of the Academy's Panel on Pricing Power in Health Care Markets." National Academy of Social Insurance, April 2015.

Berwick, Donald, and Andrew Hackbarth. "Eliminating Waste in US Health Care." *JAMA: The Journal of the American Medical Association* 307, no. 14 (2012): 1513–16.

"Best Care at Lower Cost: The Path to Continuously Learning Health Care in America - Institute of Medicine." Accessed May 10, 2013. http://www.iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx.

Biggs, Andrew, and Jason Richwine. "Overpaid or Underpaid? A State-by-State Ranking of Public-Employee Compensation." Working Paper. AEI Economic Policy. Washington, D. C.: American Enterprise Institute, April 24, 2014. https://www.aei.org/wp-content/uploads/2014/04/-biggs-overpaid-or-underpaid-a-statebystate-ranking-of-public-employee-compensation_112536583046.pdf.

"Bloomberg Best (and Worst). Most Efficient Health Care: Countries," n.d. http://www.bloomberg.com/visual-data/best-and-worst/most-efficient-health-care-countries.

Brill, Steven. *America's Bitter Pill: Money, Politics, Back-Room Deals, and the Fight to Fix Our Broken Healthcare System*. New York: Random House, 2015.

Brot-Goldberg, Zarek C., Amitabh Chandra, Benjamin R. Handel, and Jonathan T. Kolstad. "What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics." Working Paper. National Bureau of Economic Research, October 2015. http://www.nber.org/papers/w21632.

CAP Health Policy Team. "Medicare Extra for All." *Center for American Progress* (blog). Accessed February 25, 2018. https://www.americanprogress.org/issues/healthcare/reports/2018/02/22/447095/medicare-extra-for-all/.

Chandra, Amitabh, Evan Flack, and Ziad Obermeyer. "The Health Costs of Cost-Sharing," n.d., 56.

Coakley, Martha. "Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 118G, § 6½(b) Report, 2011." Boston, Mass.: Attorney General of Massachusetts, 2011. http://www.mass.gov/ago/docs/healthcare/2011-hcctd.pdf.

Commonwealth Fund. "A High Performance Health System for the United States," November 15, 2007. http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Nov/A-High-Performance-Health-System-for-the-United-States--An-Ambitious-Agenda-for-the-Next-President.aspx.

Cooper, Zack, Stuart Craig, Martin Gaynor, and John Van Reenen. "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*." Health Care Pricing Project, December 2015. http://www.healthcarepricingproject.org/sites/default/files/pricing_variation_manuscript_0.pdf .

Council of Economic Advisers. "Reforming Biopharmaceutical Pricing at Home and Abroad." Washington, D. C.: White House, February 2018. https://www.whitehouse.gov/wp-content/uploads/2017/11/CEA-Rx-White-Paper-Final2.pdf.

Emery, Gene. "Cancer Drug Prices Rising Far Faster than Inflation." *Reuters*, October 18, 2017. https://www.reuters.com/article/us-health-cancer-drug-prices/cancer-drug-prices-rising-far-faster-than-inflation-idUSKBN1CN285.

Farrell, Diana, Eric Jensen, Bob Kocher, Nick Lovegrove, Fareed Melhem, Lenny Mendonca, and Beth Paris. "Accounting for the Cost of US Health Care: A New Look at Why Americans Spend More." McKinsey Global Institute, December 2008.

Frakt, Austin. "Would Your Wages Rise Under 'Medicare for All'?" *The New York Times*, February 3, 2020, sec. The Upshot. https://www.nytimes.com/2020/02/03/upshot/wages-medicare-for-all.html.

Friedman, Gerald. "Universal Health Care: Can We Afford Anything Less?" *Dollars and Sense*, June 29, 2011. http://dollarsandsense.org/archives/2011/0711friedman.html.

Himmelstein DU, Woolhandler S. "Cost Control in a Parallel Universe: Medicare Spending in the United States and Canada." *Archives of Internal Medicine*, October 29, 2012, 1–2. https://doi.org/10.1001/2013.jamainternmed.272.

Keefe, Jeffrey. "Public-Sector Workers Are Paid Less than Their Private-Sector Counterparts—and the Penalty Is Larger in Right-to-Work States." *Economic Policy Institute* (blog). Accessed June 5, 2020. https://www.epi.org/publication/public-sector-workers-are-paid-less-than-their-private-sector-counterparts-and-its-much-worse-in-right-to-work-states/.

Kelly, Robert. "Where Can $700 Billion in Waste Be Cut Annually from the U.S. Health Care System?" Healthcare Analytics, Thomson Reuters, October 2009. https://healthleadersmedia.com/content/241965.pdf.

Koller, Christopher F., and Dhruv Khullar. "The Commercial Differential for Hospital Prices: Responses From States and Employers." *JAMA* 322, no. 8 (August 27, 2019): 723–24. https://doi.org/10.1001/jama.2019.9275.

Lopez, Eric, Gretchen Jacobson, and Larry Levitt. "How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature." *The Henry J. Kaiser Family Foundation* (blog), April 15, 2020. https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/.

McKinsey Global Institute. "Accounting for the Cost of Health Care in the United States," January 2007. http://www.mckinsey.com/mgi/rp/healthcare/accounting_cost_healthcare.asp.

Medicine, Institute of Medicine (US) Roundtable on Evidence-Based, Pierre L. Yong, Robert S. Saunders, and LeighAnne Olsen. "Prices That Are Too High." Text, 2010. http://www.ncbi.nlm.nih.gov/books/NBK53933/.

Meier, Barry, Julie Creswell, and Jo Craven McGinty. "Hospital Billing Varies Wildly, U.S. Data Shows." *The New York Times*, May 8, 2013. http://www.nytimes.com/2013/05/08/business/hospital-billing-varies-wildly-us-data-shows.html.

Nicholas C. Petris Center on Health Care Markets and Consumer Welfare. "Consolidation in California's Health Care Market 2010-2016: Impact on Prices and ACA Premiums." Berkeley, Calif.: School of Public Health, University of California, Berkeley, March 26, 2018. http://petris.org/wp-content/uploads/2018/03/CA-Consolidation-Full-Report_03.26.18.pdf.

Office of Massachusetts Attorney General Martha Coakley. "Investigation of Health Care Cost Trends and Cost Drivers," January 29, 2010. http://www.mass.gov/Cago/docs/healthcare/Investigation_HCCT&CD.pdf.

Papanicolas, Irene, Liana R. Woskie, and Ashish K. Jha. "Health Care Spending in the United States and Other High-Income Countries." *JAMA* 319, no. 10 (March 13, 2018): 1024–39. https://doi.org/10.1001/jama.2018.1150.

Pfeffer, Jeffrey. "Magnitude and Effects of 'Sludge' in Benefits Administration: How Health Insurance Hassles Burden Workers and Cost Employers." Stanford Graduate School of Business. Accessed February 27, 2021. https://www.gsb.stanford.edu/faculty-research/publications/magnitude-effects-sludge-benefits-administration-how-health-insurance.

Rhode Island Public Expenditure Council. "Analysis of Rhode Island's Debt Including Pension and OPEB Obligations – Rhode Island Public Expenditure Council." Accessed March 3, 2021. https://ripec.org/analysis-of-rhode-islands-debt-including-pension-and-opeb-obligations-2/.

Shrank, William H., Teresa L. Rogstad, and Natasha Parekh. "Waste in the US Health Care System: Estimated Costs and Potential for Savings." *JAMA*, October 7, 2019. https://doi.org/10.1001/jama.2019.13978.

Woolhandler, Steffie, and David Himmelstein. "Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs." *Annals of Internal Medicine*, February 21, 2017. http://annals.org/aim/article/2605414/single-payer-reform-only-way-fulfill-president-s-pledge-more.